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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS

On Appeal from the Supreme Judicial Court for the Commonwealth of Massachusetts

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BRIEF FOR COMMITTEE FOR COMPREHENSIVE INSURANCE COVERAGE, AMICUS CURIAE, IN SUPPORT OF APPELLEE

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INTEREST OF AMICUS CURIAE

The Committee for Comprehensive Insurance Coverage (hereinafter referred to as "Committee") is an *ad hoc* coalition of public and private groups organized by the National Mental Health Association to participate in this case. For the past decade, these groups have been active in presenting State legislatures with the facts concerning mandated benefit laws, particularly those involving coverage for mental illness and alcoholism and drug abuse.

The groups that comprise the Committee are as follows: the State of Texas, the State of North Dakota, National Mental Health Association, Alcohol and Drug Abuse Problems Association of North America, Inc., National Association of State Alcohol and Drug Abuse Di-

rectors, National Council on Alcoholism, Inc., American Mental Health Counselors Association, Association of Mental Health Administrators, Association of Psychiatric Outpatient Centers of America, International Association of Psycho-Social Rehabilitation Services, National Alliance for the Mentally Ill, National Association of State Mental Health Program Directors, National Council of Community Mental Health Centers, American Association for Marriage and Family Therapy, American Dental Association, American Nurses' Association, Inc., American Occupational Therapy Association, Inc., American Podiatry Association, Child Welfare League of America, Inc., Family Service America, National Association of Reimbursement Officers, National Association of Social Workers, Inc., National Federation of Societies for Clinical Social Work, Inc. A description of these groups is contained in an Appendix to this brief.

SUMMARY OF ARGUMENT

This case falls within the presumption that state responses to social problems affecting its residents are entitled to respect unless Congress has unmistakably intended otherwise. This is no less true with respect to the Employee Retirement Income Security Act of 1974 (hereinafter referred to as "ERISA"); despite the existence of a preemption provision, this Court has recognized the principle of dual sovereignty in both the language and holdings of its prior ERISA cases.

Unlike these prior cases, the law at issue here is within the plain meaning of the exception from preemption for laws regulating insurance. Contrary to appellant's novel interpretation of "traditional" insurance regulation, the courts have repeatedly held that mandating policy terms and/or imposing requirements on insurers to underwrite risk throughout the population are within the recognized power of the states to regulate insurance. There is no authority to the contrary.

Both the language and structure of the preemption provision indicate that the plain meaning of the savings clause represented a deliberate choice by Congress to sustain the full scope of insurance regulation. More generally, mandated benefit laws are related to Congress' contemporaneous consideration of national health insurance and were made known to Congress in that context. It is unlikely that Congress intended to resolve this crucial health insurance issue in pension reform legislation without a single indication.

Appellant's discussion of the ERISA preemption provision has ignored the fact that Congress dealt specifically with three aspects of state insurance regulation in the context of preemption, but nowhere indicated an intent to encroach on the much more fundamental authority of the states to regulate insurers. The change in the preemption provision made by the Conference Committee was primarily motivated by state regulation of prepaid legal service plans; there is no reason to believe that the change was in any way related to state regulation of insurance.

Appellant's interpretation is also inconsistent with the primary purpose of ERISA to extend participant protections. Its attempt to preempt any insurance law that indirectly affects the terms of an employee benefit plan would deprive participants of remedies under state law. The courts have repeatedly upheld such state insurance laws; the alternative would be chaotic and inconsistent decisions from federal courts fashioning a federal common law to replace specific statutory and judicial state insurance laws and interpretations.

Mental health and alcohol/drug abuse disorders present a widespread and costly human problem, despite recent progress in treatment techniques and societal attitudes. Mandated benefit laws are a key to that progress.

These laws provide a climate for resolution of the problems caused by these disorders by lowering the cost of coverage, accelerating the trend to outpatient treatment, improving access to treatment for those least able to afford it, and expressing societal recognition that these disorders are illnesses that can be treated.

Appellant's policy arguments are not supported by the evidence. Coverage for mental health and alcohol/drug abuse illnesses is not expensive, even without considering the savings in productivity and avoidance of costly treatment for related physical problems which result from treatment of the underlying causes. Nor is the administrative burden a meaningful negative consequence. Large employee benefit plans already are structured to deal with local and regional variations in costs and legal requirements. While mandated benefit laws do remove some discretion in choice of benefits, that is the essence of the insurance function of risk-sharing, and has particular applicability for mental health and alcohol/drug abuse disorders where individual denial of affliction is a serious problem. More generally, ERISA was not intended to insulate employee benefit plans from the marketplace in which every other purchaser of insurance must operate. Finally, there is no evidence that mandate laws are a significant factor in the decision to self-insure health benefits; even if it were, Congress in ERISA expressed support for self-insurance.

Mandated benefit laws are a part of the emerging governmental policy towards health care. Many of those urging preemption of state law here are in the forefront of urging more state control over the health care process in other respects. This is an issue best dealt with by the legislative branch, where it has been fully and fairly debated in dozens of states across the country. The Court should decline the invitation to overrule this inherently legislative judgment.

ARGUMENT

I. FEDERAL PREEMPTION OF STATE LAWS IS NOT FAVORED BY THE COURTS.

This Court has previously considered federal preemption of state law in a variety of contexts. While the decisions necessarily vary to comprehend individual fact patterns, several themes have emerged. First and foremost, the "exercise of federal supremacy is not lightly to be presumed." *New York State Dept. of Social Services* v. *Dublino*, 413 U.S. 405, 413 (1973), and preemption is "not favored in the absence of persuasive reasons." *Chicago & North Western Transportation Co.* v. *Kalo Brick & Tile Co.*, 450 U.S. 311, 317 (1981). This is particularly true where the area of law subject to the preemption claim is traditionally within the prerogative of the states:

> "Where, as here, the field which Congress is said to have pre-empted has been traditionally occupied by the States . . . 'we start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.' *Rice* v. *Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947).

Jones v. *Rath Packing Co.*, 430 U.S. 519, 525 (1977). The task of the Court is not to find an interpretation that ousts state law (as appellant urges here), but rather to "reconcile the operation of both statutory schemes." *Merrill Lynch, Pierce, Fenner & Smith, Inc.* v. *Ware*, 414 U.S. 117, 127 (1973).

Appellant has argued that this Court's decisions concerning ERISA have, in effect, reversed the historical presumption and enunciated an unequivocal rule that Congress intended to preempt all state laws affecting employee benefit plans. This misrepresents both the language and holdings of these cases.

In *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), the Court considered whether a New Jersey law

prohibiting offsets from pension benefits for workers compensation payments was preempted by ERISA. The Court's affirmative holding followed a discussion of the legislative history of ERISA which showed that Congress had intended to permit such offsets. There is nothing noteworthy about a decision that holds that a state law in conflict with federal law is preempted. On the contrary, the Court prefaced its holding with a discussion of preemption generally, making it clear that the presumption against preemption remained the general rule under ERISA. *See* 451 U.S. at 522.

Similarly, the result in *Shaw* v. *Delta Airlines*, 103 S. Ct. 2890 (1983), does not aid appellant. In that case, the Court held that New York could not compel an employer to amend its existing employee benefit plan to comply with a disability benefits law mandating benefits, but that it could require the employer to provide the disputed coverage in some fashion because of the exemption in Section 4(b) of ERISA, 29 U.S.C. Section 1002(b), for plans "maintained solely for the purpose of complying with . . . disability insurance laws." Thus, the decision sustains the ability of the state to mandate benefits. Moreover, the decision provides more opportunity for states to mandate the provision of certain fringe benefits than is arguably present here because *Shaw* applies to an employer regardless of the funding mechanism it chooses, while this case affects only those employers which purchase insurance.[1] Perhaps most significantly, the Court demonstrated its historical presumption

[1] Thus, the protestations of appellant/*amici* concerning indirect regulation of employee benefits by the states should not be accorded any weight. As a general proposition, no state could, as appellant/*amici* suggest, prohibit workers compensation offsets because such laws would conflict with ERISA as interpreted by this Court in *Alessi*. Under *Shaw*, however, any state could require even self-insured employers to provide mental health or alcohol/drug abuse coverage under its disability laws, regardless of the outcome of this case.

against preemption by taking a circuitous route to save New York's law—a route which had seemingly been foreclosed only two years previously in *Alessi*.[2]

In sum, this Court's two previous ERISA decisions do not manifest any departure from the general presumption against preemption of state laws. On the contrary, in language and result, the Court has emphasized its commitment to respecting the sovereignty of the states.

II. STATE LAWS MANDATING THE CONTENTS OF INSURANCE POLICIES ARE WITHIN THE TRADITION OF INSURANCE REGULATION.

A. Mandating Policy Terms Is an Integral Part of the State Regulation of Insurance.

Forty years ago, the Court held that state insurance regulators had "full power to prescribe the forms of contract [and] the terms of protection of the insured." *Hoopeston Canning Co.* v. *Cullen*, 318 U.S. 313, 321 (1943). More recently, in *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969), the Court described state regulation of insurance as focussing on, among other things, "the type of policy which could be issued." Thus, this Court has recognized that control over insurance contracts is an integral part of insurance regulation, and this conclusion has permeated the courts in all jurisdictions. *See* 2A *Couch on Insurance 2d* Section 21:31 (Rev. Ed. 1984); 43 *Am. Jur.2d* Section 26 (1983 Supp.).

[2] In *Alessi*, the Court rejected the argument that the provisions of a state's workers compensation law (which appears in the same exemption in ERISA as the disability laws considered in *Shaw*) survived preemption, reasoning that that section exempts plans, not laws from ERISA. *See* 451 U.S. at 523, n. 20. This is no doubt a better reading of the statute: Congress could have reasonably believed that plans maintained "solely" to comply with those laws would be so pervasively regulated by the state as to obviate the need for federal regulation under ERISA. Had Congress intended to save the laws themselves, it would have done so in the savings clause within the preemption provision.

Appellant has fared poorly in state courts with this argument because those courts have a long history of dealing with state insurance regulation. As the Court of Appeals for the State of Maryland commented, in the course of rejecting an identical argument by appellant in a case presenting the issue here:

> "A great many of the regulations contained in the Maryland Insurance Code, as well as the insurance law of other states, are provisions mandating specific coverages in various types of insurance policies. Much of the litigation concerning state regulation of insurance involves statutory provisions requiring specified coverages in different classes of insurance policies."

Insurance Commissioner v. *Metropolitan Life Insurance Co.*, 463 A.2d 793 (Md. 1983).

B. Assuring Comprehensive Coverage of Risks Is an Integral Part of the State Regulation of Insurance.

This Court has recently held that spreading and underwriting risk are the "primary elements" of insurance. *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 211 (1979). This is true not only with respect to the operation of a single policy, but also to the function insurance plays in the larger social context—what one theorist has called the "socialization of risk." *See* Kimball, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law*, 45 Minn. L. Rev. 471, 511-514 (1961). Not surprisingly, this concept has been reflected in state insurance regulation. As one regulator has commented:

> "[T]his attitude is most strongly expressed concerning those types of insurance coverages deemed to be social in nature—for example, automobile, homeowner, and health insurance. Government is now expected to strengthen or replace the private insurance mechanism when the shortage of coverage is serious. Thus, ready availability of adequate coverage in certain lines has emerged as a fundamental objective of insurance regulation."

Huff, *Development of Public Policy from the Viewpoint of a State Insurance Regulator*, 1975 Ins. L. J. 393, 395.

This Court has recognized and sanctioned the risk-spreading nature of insurance regulation. In *California Auto Association Inter-Insurance Bureau* v. *Maloney*, 341 U.S. 105 (1951), the Court held that a state may require insurers to participate in a compulsory assigned risk pool to assure the availability of insurance coverage. The Court noted the states' pervasive authority over insurers, including the requirement "that local needs be serviced by the business." *Id.* at 110. *See also Osborn* v. *Ozlin*, 310 U.S. 53, 65 (1940) (explaining the states' "special relation to insurance").

Relying on these precedents, a number of courts have upheld the validity of mandated benefit laws. For example, in *Health Insurance Association of America* v. *Harnett*, 376 N.E. 2d 1280, 1284 (N.Y. 1978), a unanimous court held that a law mandating maternity care coverage in health insurance contracts passed muster as an aspect of "the Legislature's regulatory authority over the insurance industry." *See also Insurers' Action Council, Inc.* v. *Markman*, 490 F. Supp. 921 (D. Minn. 1980), *aff'd*, 653 F.2d 344 (8th Cir. 1981); *American Family Life Assurance Co.* v. *Commissioner of Insurance*, 388 Mass. 468, 446 N.E.2d 1061 (1983); *Blue Cross of Virginia* v. *Commonwealth of Virginia*, 269 S.E.2d 827 (Va. 1980). No court has held that mandate laws exceed the authority of the states to regulate insurance.

There can be little dispute that both mandating policy terms and requiring the underwriting of risk across the population are well-recognized aspects of "traditional" insurance regulation. We urge the Court to refrain from sustaining appellant's attempt to cast doubt on an issue that has been conclusively and repeatedly resolved against it.

III. ERISA WAS NOT INTENDED TO PREEMPT MANDATED BENEFIT LAWS.

Nine courts have considered the issue before this Court—with the exception of one district court decision (now on appeal), all have sustained state mandated benefit laws. *See American Progressive Life & Health Insurance Co. of New York* v. *Corcoran*, 715 F.2d 784 (2d Cir. 1983); *Wayne Chemical Corp.* v. *Columbus Agency Service Corp.*, 567 F.2d 692 (7th Cir. 1977); *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. den.*, 435 U.S. 980 (1980); *Insurers' Action Council, Inc.* v. *Heaton*, 423 F. Supp. 921 (D. Minn. 1976); *Attorney General* v. *The Travelers Insurance Co.*, 463 N.E. 2d 548 (Mass. 1984); *Insurance Commissioner* v. *Metropolitan Life Insurance Co.*, *supra*; *New Hampshire-Vt. Health Service* v. *Whaland*, 410 A.2d 642 (N.H. 1979); *Metropolitan Life Insurance Co.* v. *Whaland*, 410 A.2d 635 (N.H. 1979).[3] In addition, the Department of Labor, through the Solicitor General, has taken the position that mandated benefit laws are not preempted by ERISA. *See Memorandum for the United States as Amicus Curiae*, *Wadsworth* v. *Whaland*, 435 U.S. 980 (1978) (hereinafter cited as "*U.S. Memorandum*"). This near-unanimity from all sectors of the judicial system, supported by the opinion of the agency responsible for enforcement of ERISA, demonstrates the comparative strength of the legal arguments.

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[3] Appellant has argued that the *American Progressive* opinion involved only state regulation of maximum commissions for sales of life insurance, but it has ignored the court's additional holding that another law at issue which regulated "the terms of policies sold to [employee benefit] plans" was not preempted. *See* 715 F.2d at 787.

Similarly, appellant has argued that *Wayne Chemical* involved only an Indiana insurance law forbidding the sale of insurance without a certificate. The court, however, also sustained the applicability of a mandated benefit law which provides that all insurance policies must include a provision extending coverage to disabled minors.

A. Congress Was Aware of That Aspect of the Tradition of Insurance Regulation Which Includes Mandated Benefit Laws When It Enacted ERISA.

1. *The language and structure of the statute evidences Congress' awareness of the scope of state regulation.*

Appellant's case is based on the proposition that Congress intended to distinguish between different types of insurance regulation for purposes of the savings clause. No such distinction appears in the language. On the contrary, the clause applies to "any law of any state which regulates insurance"—hardly an expression of an intent to limit the type of law covered.[4]

The court's holding in *Wadsworth* v. *Whaland*, *supra*, was based primarily on an examination of the structure of the preemption provision. It recognized that the savings provision would be meaningless unless it saved from preemption state laws regulating insurance which also indirectly regulate employee benefit plans since no other state law regulating insurance would be subject to preemption under ERISA even in the absence of the savings provision. *See also U.S. Memorandum*, *supra*, at 6.

The language of the preemption provision also shows Congressional awareness of the scope of insurance regulation. Section 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B) —the so-called "deemer" clause—creates an exception to the savings clause for insurance regulation to prevent a state from regulating a self-insured employee benefit plan as an insurer. The language chosen by Congress is sig-

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[4] When Congress desires to make the kind of distinctions urged by appellant, it knows how to do so directly. In 1983, Congress amended the preemption provision to increase the authority of the states to regulate certain self-insured welfare plans. The amendment distinguishes between state insurance laws which assure that benefits will be paid when due and "any law of any state which regulates insurance." *See* P.L. 93-473, Title III, Section 382(b), 96 Stat. 2613, *codified*, 29 U.S.C. 1144(b)(6)(A).

nificant: it provides that an employee benefit plan shall not be deemed to be an insurance company "for purposes of any law of any state purporting to regulate insurance companies [or] *insurance contracts*" (emphasis added). Thus, Congress evidenced its awareness that insurance regulation extended to the contracts issued by insurers, as well as the insurers themselves.

2. The relationship of mandated benefit laws to national health insurance shows Congress' awareness of this aspect of insurance regulation.

As an Associate General Counsel of the Health Insurance Association of America ("HIAA") has written, "a great deal of activity took place with respect to minimum standards" in health insurance during the period 1972-1974. Peel, *Regulatory Developments in Minimum Standards for Health Insurance Policies*, 13 Forum 680, 681 (1978). These included model acts and regulations promulgated by the National Association of Insurance Commissioners ("NAIC") mandating benefits for individual health insurance coverages, catastrophic coverage, conversion requirements, and newborn coverage. *See* Hanson, *The Private Insurance Industry and State Insurance Regulatory Alternatives to Federally Enacted Comprehensive National Health Insurance Legislation*, 6 Toledo L. Rev. 677, 712-713 (1975); II *NAIC Proceedings* 430 (1973); I *NAIC Proceedings* 414, 425 (1974).

The NAIC had a twofold objective for the emphasis on mandated benefit laws in health insurance: one was to address a series of problems on the merits, particularly availability of adequate coverage for all persons; the other was to create a "viable alternative to national health insurance." II *NAIC Proceedings* 438 (1976). *See also* 128 Cong. Rec. H9608 (Dec. 18, 1982) (testimony of Sen. Matsunaga concerning the origin of the Hawaii mandated benefits law).

Congress was aware of this activity, and the reasons for it because the period of its consideration of ERISA coincided with its detailed examination of twenty-two separate bills dealing with national health insurance. In 1974, a representative of the NAIC testified before the House Ways & Means Committee—one of the committees then considering ERISA—about state regulatory efforts undertaken to respond to the issues highlighted by Congress in the national health insurance debate. In discussing mandated benefits, he stated: "This is definitely going to be the mainstream of legislative activity in health insurance at the state level this year and next year." *Hearings on National Health Insurance before the House Committee on Ways and Means*, 93d Cong., 2d Sess. 2647 (1974).

It is inconceivable that a Congress preoccupied with national health insurance would have been unaware of the maelstrom of activity on the state level concerning mandated benefits during 1972-1974 undertaken in response to its deliberations. It is equally inconceivable that it chose to resolve an issue of critical importance to its contemporaneous examination of national health insurance in the context of pension reform legislation without a single indication.

B. The History of the Preemption Provision Does Not Show Any Intent To Limit State Regulation of Insurance Contracts.

The legislative history of ERISA shows that Congress deliberately limited the authority of state insurance regulators in three areas: regulation of pension plans, regulation of self-insured trusts, and joint enforcement of ERISA. We contend that Congress did not also intend, *sub silentio*, to enact the further limitation urged by appellant.

1. Congress deliberately limited the authority of the states in three areas.

The ten years of Congressional deliberation that preceded ERISA's regulation of the private pension system sparked a number of states to enact comprehensive pen-

sion laws. *See Malone* v. *White Motor Corp.*, 435 U.S. 497 (1978). This became an area of contention between federal and state regulation of employee benefit plans. In 1973, the NAIC presented testimony describing the new pension legislation several states had enacted. *See Statement of Stanley C. DuRose, Jr., before the Subcommittee on Private Pension Plans, Senate Committee on Finance*, 93d Cong., 2d Sess. (1973). In the alternative, the NAIC sought a role in the administration and enforcement of the federal standards imposed by ERISA. *See id.*; II *NAIC Proceedings* 418 (1973). Congress, however, declined to adopt either suggestion, opting instead for federal minimum standards for pensions and cooperative enforcement arrangements between the Secretary of Labor and state officials. *See* ERISA Section 506, 29 U.S.C. 1146; S. Rep. No. 93-127, 93d Cong., 1st Sess. 35 (1973).

The third limitation was more controversial. As early as 1961, the NAIC had noted the trend towards self insurance of health and welfare benefits. I *NAIC Proceedings* 76 (1963). A number of states had responded by "deeming" self-insured trusts to be insurance companies under state law. *See* Goetz, *The Regulation of Uninsured Employee Welfare Plans Under State Insurance Laws*, 1967 Wis. L. Rev. 319. While ERISA was being considered, the highest courts in New York and Missouri accepted cases presenting this issue. *See State ex rel. Farmer* v. *Monsanto Co.*, 517 S.W. 2d 129 (Mo. 1975); *Mutual Life Ins. Co.* v. *New York State Tax Comm'n.*, 32 N.Y. 2d 348, 298 N.E. 2d 672 (1973).

The House responded by drafting the deemer provision. This made it clear that states could control neither the solvency of such trusts, nor their content. The Senate, however, did not address this issue, leaving the Conference Committee with the task of resolving the difference. A further measure of the controversy surrounding the issue is that the NAIC vigorously opposed the House pro-

vision and the Committee staff was evenly split. *See Staff of Conference Committee on H.R. 2, Summary of Differences Between the Senate Version & House Version of H.R. 2*, 93d Cong., 2d Sess. 33 (1974); Sullivan, *Regulatory Aspects of the ERISA of 1974*, 1974 Proc. Leg. Soc. Am. Life Conv. 15, 49-52.

2. *The Conference Committee version of preemption.*

Appellant's presentation of the floor debate on the Conference Report does not explain what impelled the conferees to make a change in the preemption provision. A number of commentators, including the then-Associate General Counsel of appellant Travelers Insurance Co. have reached the same conclusion: "The concern with a professional society or association seems, from the floor debate, to have been the major impetus behind the revised, compromise preemption provision." Okin, *Federal Preemption of State Law Under ERISA: An Examination of the Effects of the Federal Mandate in the Light of Authoritative Precedent Under the Supremacy Clause, the McCarran-Ferguson Act & the Legislative History*, 24 A. of Life Ins. Couns. Proc. 115, 149 (1976); *see also* Dowd & Herlihy, *ERISA and Preemption* (ABA 1975); Note, *The Effect of ERISA on Prepaid Legal Services*, 27 Baylor L. Rev. 566 (1975).

Appellant's editing of the floor debate has obscured this focus on state regulation of prepaid legal service. For example, the only laws specified by Representative Dent as targets of the revised preemption provision were those of "any professional society or association operating under code of law." 120 Cong. Rec. H8701 (Aug. 20, 1974). Similarly, Senator Williams explained that the revision was to prevent "state professional associations" from hindering the development of "prepaid legal service programs." 120 Cong. Rec. S15742 (Aug. 22, 1974).[5]

[5] Fearful that Representative Dent's zeal for saving prepaid legal service plans from state regulation had misrepresented the intent of the conferees, Senators Javits and Williams engaged in a clari-

Finally, Representative Dent noted that the conferees had "followed to a large extent the same approach" Congress took in the Health Maintenance Organizations Act of 1973 ("HMO Act") preemption provision. 120 Cong. Rec. H8701 (Aug. 20, 1974). That provision does not broadly preempt state law;[6] its intent is to prevent states from controlling the structure of HMO's, as state bar associations were doing with prepaid legal service plans. *See Symposium Issue—Prepaid Legal Services*, 27 Baylor L. Rev. 403 (1975).

We are not suggesting that preemption is limited to prepaid legal service plans, but there is also no reason to ignore the conferees' identification of the reason behind the expansion of the preemption provision. The Court should be wary of enlarging Congressional intent beyond the evidence, particularly in the area of insurance regulation. Congress was aware of the extent of that regulation of employee benefit plans and resolved the potential conflicts in several specific areas. It is hardly likely that a Congress that thoroughly debated the propriety of state regulation of the terms of contracts for self-insured plans also intended to encroach on the states' historical power over insurance companies and contracts *sub silentio*.

C. State Insurance Regulation Plays A Major Role In Effectuating The Purposes of ERISA.

State health insurance regulation, including mandated benefit laws, is not inconsistent with any provisions of

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fying colloquy on the Senate floor—another indication that that was the primary concern of the conferees. *See* 120 Cong. Rec. S15743 (Aug. 22, 1974).

[6] *See* 42 U.S.C. Section 300e-10. In fact, the HMO Act "anticipates concurrent state regulation." *Hewlett -Packard Co.* v. *Barnes*, 571 F.2d 502, 504 (9th Cir. 1978). Most states regulate HMO's extensively. *See* Recent Developments, *Health Maintenance Organizations Act of 1973—Federal Regulation and Support of Prepaid Group Health Care Plans—Preemption of Restrictive State Laws and Practices*, 27 Vand. L. Rev. 1043 (1974).

ERISA, and neither appellant nor *amici* cite any such provisions.[7] In contrast to regulation of pension plans, ERISA is virtually silent as to welfare plans, particularly the substantive content of them. The only conclusion that can be justifiably drawn from ERISA concerning welfare plans is that Congress did not see fit to enact any special protections for participants in those plans.

Subsequent judicial experience with ERISA demonstrates the reason for Congress' decision. Numerous courts have held that state insurance law supplements ERISA—that it, in appellant's words, affects "the relationship between the plan itself and the plan's beneficiaries"—by providing remedies to welfare plan participants. *See Taggart Corp.* v. *Life & Health Benefits Administration*, 617 F.2d 1208 (5th Cir. 1980); *Wayne Chemical Corp.* v. *Columbus Agency Service Corp., supra; Rehabilitation Institute* v. *Blue Cross & Blue Shield*, 5 E.B.C. 2265 (W.D. Pa. 1984); *McLaughlin* v. *Connecticut General Life Ins. Co.*, 656 F. Supp. 434 (N.D. Cal 1983); *Lederman* v. *Pacific Mutual Life Ins. Co.*, 494 F. Supp. 1020 (C.D. Cal. 1980). *See also Brief of the Secretary of Labor, Donovan* v. *Dillingham*, 688 F.2d 1367 (11th Cir. 1982) (*en banc*) (expressing position of Department of Labor that ERISA and state insurance law both provide remedies for participants of insured plans).

Thus, appellant's interpretation of the savings clause would not only affect mandated benefit laws; it would also deprive participants of substantive remedies currently available under state insurance law. Even assuming, *arguendo*, that Congress was concerned about disincentives to welfare plans, there can be no question that pro-

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[7] The only "inconsistency" claimed by appellant is that ERISA expresses a Congressional recognition of the voluntary nature of plans and the costs imposed upon them. But, the fragmentary evidence in the legislative history is directed at pension plans; there is no evidenec that Congress was concerned about disincentives to welfare plans arising from ERISA or state insurance law.

viding protections for participants was the single most important policy expressed in ERISA.

Appellant's interpretation, however, would do more than vitiate participant protections; it would lead to chaotic and inconsistent adjudications that would be in no one's interest, least of all appellant and *amici*. Aside from the difficulty of deciding what is "traditional" insurance regulation, we refer to the chaos created by the preemption of state laws providing remedies under insurance contracts.

This point is graphically demonstrated by comparing the district court and appellate court decisions in *Wayne Chemical Corp.* v. *Columbus Agency Service Corp.*, 426 F. Supp. 316 (N.D. Ind.), *aff'd*, 567 F.2d 692 (7th Cir. 1977). The issue was whether a disabled minor lost insurance coverage once he became nineteen years old. The district court held that an Indiana insurance statute extending coverage under such circumstances was preempted by ERISA, but that the same result should be reached under "federal common law." The court, however, expressed concern that this approach could result in excessive litigation costs and inconsistent results because of uncertainty about a court's notion of federal common law (426 F. Supp. at 321, 326). The court of appeals affirmed on a different basis, holding that the Indiana statute extending coverage was not preempted by ERISA. Not surprisingly, the court of appeals did not choose to follow the district court across the rocky terrain of fashioning a federal common law when there was a provision of state insurance law that applied specifically to the subject.

* * * *

There is much mischief in appellant's argument. It has suggested that this Court overrule decades of legal precedent concerning the scope of state insurance regulation, thereby simultaneously opening a hole in the heart of ERISA that will engage the ingenuity of federal

courts for years to come. It has suggested that the Court radically change its historical approach to preemption by encouraging legal "interpretation" created to ignore the absence of any indication that Congress intended to preempt certain laws. Where, as here, the statute, legislative history and judicial precedent all point to an answer that preserves the coordinate sovereignty of our system of government, the Court's direction should be clear.

IV. THE POLICY CONSIDERATIONS SUPPORT MANDATED BENEFIT LAWS.

A. Mandated Benefit Laws For Mental Health and Alcohol/Drug Abuse Coverage Are In the Public Interest.

Fifty years ago, alcoholism, drug abuse and mental illness were viewed as "different" from physical disorders. Causes were mysterious, cures rare, and social stigma was attached to victims. The medical establishment treated only the physical problems related to these diseases, while neglecting the less tangible underlying causes. *See* Cooper, *Private Health Insurance Benefits for Alcoholism, Drug Abuse and Mental Illness* (Intergovernmental Health Policy Project 1983).

Today, these problems are considered illnesses that are treatable by known therapies with effective cure rates. Unfortunately, these treatments have evolved in large measure because of the recognition by society of how widespread and costly these disorders are. It has been estimated that 28-39 percent of adults experience at least one mental health disorder in their lifetime,[8] while an estimated 14.7 million Americans suffer from alcoholism or problem drinking and their numbers are increasing by 400,000 a year.[9] The societal costs are staggering: an

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[8] Robins, *et al.*, *Lifetime Prevalence of Specific Psychiatric Disorders in Three Communities*, 41 Arch. Gen. Psych. 949 (1984).

[9] Fein, *Alcoholism in America: The Price We Pay* (Care Institute 1984).

estimated $23.6 billion in direct and $28.9 billion in indirect costs related to mental health; $11.9 billion direct and $97.1 billion indirect costs relating to alcoholism and substance abuse.[10]

As the prevalence and costs of these disorders have intruded into the collective awareness of society, treatment methods have undergone a radical transformation. In the 1930's, treatment for mental illness generally meant long-term institutionalization in a public facility. By the next decade, two major alternatives had emerged: the development of effective psychoactive drugs and a shift in care from institutions to community-based settings. *See* Sharfstein, et al., *Health Insurance and Psychiatric Care: Update and Appraisal* (Am. Psych. Press 1984) at 2-3.

A similar revolution has occurred in the treatment of alcoholism and substance abuse. As recently as twenty years ago, persons suffering from such disorders were not even allowed admission to general hospitals. *See* Rosenburg, *Survey of Health Insurance for Alcoholism: Inpatient Coverage* (1979). Today, community-based settings and outpatient facilities specializing in treatment for these disorders are well-known.

Despite the substantial progress in societal attitude and treatment methods, many perplexing problems remain. Two of the most serious—assuring adequate coverage to all of those in need and financing that coverage—

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[10] Harwood, *et al., Economic Costs to Society of Alcohol, Drug Abuse & Mental Illness—1980* (Research Triangle Institute 1984).

These costs include the facts that more people are admitted to hospitals because of these disorders than for any other illness; industry suffers reduced productivity (emotional illness accounts for more abstenteeism from work than any other illness, except for the common cold); alcohol and substance abuse disorders are linked to motor vehicle crashes and household and workplace accidents, and those afflicted commit a disproportionate amount of criminal acts.

are the motivating factors behind mandated benefits laws. As both the federal and state governments have concluded, it is not enough to recognize the severity of the problem and that solutions are available; one must also express the political will to make those solutions a reality.

The federal government's role in the treatment of mental health and alcohol/drug abuse disorders has been crucial. Congress has repeatedly acted to shift the focus of treatment away from institutionalization and to broaden coverage throughout the population. See Wirthin, *Trends in Patient Care Episodes in Mental Health Facilities 1955-1977* (NIMH 1980). Even more significant was the action of the Congress in the HMO Act, which is, in part, a mandated benefit law because it requires federally qualified HMO's to offer coverage for mental health and alcohol/drug abuse disorders. *See* 42 U.S.C. 300e-1(1). As the Senate Report explains:

> "The Committee heard impressive testimony concerning the inclusion of mental health services as a basic required benefit. The Committee views the inclusion of mental health service as . . . a wise investment of money and personnel. . . .
>
> The Committee has included preventive diagnostic and medical and psychological treatment of the abuse of or addiction to alcohol and drugs as a basic benefit requirement. The Committee wishes to emphasize its view that drug abuse and alcoholism are diseases and should be treated as such."

S. Rep. No. 93-129, 93d Cong., 1st Sess. (1973), *reprinted in* 2 U.S. Code Cong. & Ad. News 3044 (1973).

While Congress was attacking the problem by mandating benefits offered by federally-qualified HMO's, many states were doing precisely the same thing by mandating benefits offered by state-licensed insurance companies. Unlike the financing of other ailments, treatment of mental health and alcohol/drug abuse disorders has

been primarily public.[11] The predominant reason was that the insurance industry had failed to react to the evolution of societal attitude and treatment methods with respect to these diseases. Many insurers either offered no coverage at all, or limited coverage to treatment in a hospital, thereby impeding the trend to outpatient treatment. *See* Reed, et al., *Health Insurance & Psychiatric Care: Utilization and Cost* (Am. Psych. Press 1972); *Rosenburg, supra.* Even more distressing was that the relation of a lower soceoeconomic class to mental health and alcohol/drug abuse problems had been clearly established, leaving those most in need of treatment without the means of obtaining it. *See* Hollingshead, *et al., Social Class and Mental Illness* (John Wiley & Sons 1958).

Despite the posture of the insurance industry here, it has also recognized that the changes in public attitude and treatment methods must be reflected in its attitude towards insurance coverage. In 1968, the HIAA warned its members that "the absence of coverage for mental illness treatment can result in under-insurance," and recommended that insurers include coverage for mental illness, alcoholism and drug addiction. Follman, *Insurance Coverage for Mental Illness* (American. Man. Ass'n. 1970) at p. 58. The goal, according to Mr. Follman (then on the staff of the HIAA) was "to assure an adequate and pluralistic system of financing that will enable all persons to enter the mainstream of health care on an equal basis and with a reasonable level of quality assured." *Id.* at 37.

State mandate laws are intended to respond to that challenge through the insurance mechanism of spreading risk throughout the population. The Massachusetts law

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[11] *See, National Drug and Alcoholism Treatment Utilization Surveys: 1979-1982,* 8 Alcohol Health & Research World 44 (1983); Sharfstein, *et al., Health Insurance and Psychiatric Care: Update and Appraisal, supra* at 7.

at issue here is an example of why mandated benefit laws are an integral part of the fight against these illnesses. As the Superior Court found, the law has had the following effects:

> —recognition that mental illness is a national *health* problem with a staggering price tag;
>
> —a shift from in-patient to outpatient delivery of treatment;
>
> —an increase in treatment for poor, working and middle class persons; and
>
> —a shift in financing from the public to the private sector.

Appendix to Jurisdictional Statement 51a-53a.

In sum, we urge this Court to recognize both the reasons for and the effectiveness of mandated benefit laws in solving these important health problems.

B. The Policy Concerns Raised By Appellant Are Contradicted By The Evidence.

1. *Mandated benefit laws for mental health and alchohol/drug abuse are cost-effective.*

Amicus HIAA has asserted that mandated benefit laws raise the cost of insurance 10-20 percent. There is no citation to any authority that supports this assertion. In fact, the evidence is to the contrary.

First, one of the principal objectives of mandated benefit laws is to reduce the cost of coverage by eliminating adverse selection. Where only a few insurers in a market offer coverage for a particular disorder, those persons who need that coverage will choose that insurer in disproportionate numbers, and the insurer with the coverage must price it higher to account for the adverse selection of poor risks. But, where all insurers must offer the coverage, there is less risk of adverse selection

and the rates can be lowered to reflect the assumption that each insurer will attract a pool of average risks.[12]

Second, the evidence from a variety of sources is that coverage for mental health and alcohol/drug abuse disorders is not expensive compared to the total cost of insurance, and is nowhere near the "estimate" provided by HIAA to the Court. This is true for both mental health[13] and alcohol/drug abuse.[14] Mandated benefit laws moderate that cost by providing a financing base and encouraging use of less expensive outpatient services.[15]

Finally, no discussion of cost can ignore the "offset" effect of treatment for these disorders. This includes benefits to employers in the form of improved productivity and reduced absenteeism.[16] It also includes the reduction in health care costs associated with treating physical ailments related to these disorders.[17]

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[12] The effect of mandated benefit laws on adverse selection and the cost of insurance was the subject of expert testimony in Superior Court (Joint Appendix 225-230) and a finding of that court (Appendix to Jurisdictional Statement 51a).

[13] See *e.g.*, VonKorff, *et al., Mental and Nervous Disorders: Utilization and Cost Survey* (NIMH 1979); Reed, *et al., Health Insurance and Psychiatric Care: Utilization and Cost, supra*; Jameson, *The Effects of Outpatient Psychiatric Utilization on the Costs of Providing Third-Party Coverage,* 16 Medical Care 383 (1978); Lowery, *et al., Analysis of Insurance for Mental Disorder,* 137 Am. J. of Psychiatry 9 (1980).

[14] See, e.g., Cooper, *Private Insurance Benefits for Alcoholism, Drug Abuse and Mental Illness, supra*; Holder, *et al., Medical Care and Alcoholism Costs and Utilization: A Five-Year Analysis of the California Pilot Project to Provide Health Insurance Coverage For Alcoholism* (1981); McCarthy, *Insurance Coverage for Treatment of Alcoholism: Analysis and Proposed Actions* (1982).

[15] *See* McGuire, *Mandated Mental Health Benefits in Private Health Insurance Policies: A Legal & Economic Analysis* (Yale U. 1981).

[16] *See* Barrie, et al., *Mental Distress As A Problem For Industry* (Springer-Verlay 1980); Jones, *et al., Summary of Impact of Alcoholism Treatment on Medical Care Utilization & Cost* (ADAMHA 1979).

In sum, the addition of coverage may increase the cost of insurance in the context of an individual case, but public policy is not based on one case, particularly in the area of insurance. Viewed from the perspective of social policy, coverage for mental health and alcohol/drug abuse illness is both inexpensive and cost-effective.

2. *Appellant*/amici *have overstated the administrative burdens.*

Appellant/*amici* have offered no data concerning the prevalence of totally uniform plans allegedly affected by mandate laws. As the Bureau of Labor Statistics has pointed out, benefits may well vary in establishments for a number of reasons. Indeed, "hospital, surgical, and medical benefits through Blue Cross and Blue Shield programs generally vary from locality to locality." U.S. Bureau of Labor Statistics, I *Digest of Selected Health & Insurance Plans, 1977-79 Edition,* p. vii (1978). In addition, virtually all large employers and Taft-Hartley plans include participants with at least two different types of health coverage. Pursuant to the HMO Act, 42 U.S.C. Section 300e-9, all employers and Taft-Hartley plans with more than twenty-five participants must offer employees the option to join an HMO.

Even within a supposed "uniform" health insurance contract, the plan cannot avoid local and regional differences and the administrative complexities those differences create. Under most major medical programs, reimbursement for physician fees is determined by usual, customary and reasonable criteria, established by the prevailing charges of practitioners in a geographic area for each procedure. Thus, a participant in New York

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[17] See, *e.g., Id.*; Mumford, *et al., A New Look at Evidence About Reduced Cost of Medical Utilization Following Mental Health Treatment,* 141 Am. J. of Psychiatry 1145 (1984).

who has an appendectomy will be charged, on the average, $875, while a participant in Wyoming will be charged $399.[18] Under the common UCR benefit structure, these participants will have different out-of-pocket costs, and the plan or insurance company will have to take the residence of the participant into account when paying the benefit.

Insurers and plans have been notably unsuccessful in arguing that variations in state laws create excessive administrative burdens. As the Superior Court concluded in this case after trial:

> "Mandated benefit laws do impose an administrative burden. However, the diversity of eligibility requirements for each state for example, would not be any more complex or burdensome to interstate commerce than various other diverse multi-state regulatory schemes such as workmen's compensation laws."

Appendix to Jurisdictional Statements 54a. Similarly, one court, after hearing evidence in a case brought by eleven insurers challenging Minnesota's mandated benefit law, concluded:

> "[T]he evidence indicates that insurance companies and employers with multistate group policies are regularly faced with meeting varying state requirements, and that the insurers can do so by merely attaching a rider or an endorsement which limits certain coverages to specific states."

Insurers' Action Council, Inc. v. *Markman, supra,* 490 F. Supp. at 928.

Benefit administration on the level of a multistate welfare plan is inherently a time-consuming, expensive and detailed task that is designed to deal with numerous

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[18] These figures are from the *Medicare Directory of Prevailing Charges 1983* (Health Care Financing Administration 1983) at pages 167, 275. .The Medicare Part B program uses a UCR system for paying benefits.

variables. Mandated benefit laws do not change that process; whether or not such laws exist, the plan must engage in the same administrative process applicable to all benefits. Appellant/*amici* have not proved how the addition of coverages would cause any significant additional cost or complexity.

3. *Freedom of choice of benefits is not a significant factor under ERISA.*

Many purchasers of insurance pay for coverages they do not need. That is one of the principles of insurance—to spread the risk across the population of those purchasing a policy to include persons who will never incur the risk insured against. Thus, the Court of Appeals for New York has held, in rejecting this argument against a mandated benefit law, that providing coverages to those who might not want it is part of the "concept—basic to insurance—of risk sharing." *Health Insurance Association of America* v. *Harnett, supra,* 376 N.E.2d at 1285.

Second, removal of choice is essential to providing adequate coverage for mental health and alcohol/drug abuse disorders. One of the most difficult problems in treating these illnesses is that those suffering from them deny that they have a problem, or are afraid to admit it because of the fear of adverse reactions from co-workers or their employer. In this respect, mandated benefit laws do not restrict choice as much as they remove the necessity of publicly announcing choice.

Finally, and most fundamentally, there is no indication that Congress intended to isolate employee benefit plans from the realities of the marketplace. The United States made this point clearly in its support of mandated benefit laws under ERISA: "Congress did not intend to confer any special exemption or privilege on [plans] as insurance buyers. Insurance sales to them must conform to the same rules as those to any other insurance buyer . . ." *U.S. Memorandum, supra,* at 8.

4. *Mandated benefit laws are not a significant factor in the decision to self-insure health benefits.*

The trend towards self-insurance began in the decade prior to the passage of ERISA. Congress' view was expressed in ERISA; there is no way to read the "deemer" clause as other than Congressional approval of self-insurance. Thus, even if appellant/*amici* were correct that mandated benefit laws encourage self-insurance, their argument would founder on the ground that discouraging self-insurance is not one of the policies expressed by Congress in ERISA.

Appellant/*amici* are not, however, correct in arguing that mandated benefit laws are a significant factor in the decision to self-insure. As the Superior Court found here:

> "There is no credible evidence that the potential cost impact of [the Massachusetts statute] has forced any policyholder of any insurance which has previously complied with [the statute] to discontinue such coverage and become a self-insurer . . .
>
> There is no credible evidence that the trend towards self-insurance is more pronounced in Massachusetts by virtue of the enactment of [the statute]."

Appendix to Jurisdictional Statement 55a.

Similarly, a New York study identified the following factors encouraging self-insurance: savings through a "one-shot" cash flow advantage due to the lag in first year claims; control of costs by assuming more direct administrative control over benefits; and investment yields of unused assets. *See* New York State Health Advisory Council and New York Business Group on Health, *Self-Insurance and Health Care Benefits in New York State: An Explanatory Statement and Descriptive Analysis* 17 (December, 1982). Its conclusion on mandate laws was direct:

> "Self-insured . . . plans generally responded that the 'burden of state insurance mandates' or 'redirection in mandated services' did not figure prominently in their decision to self-insure. . . ."

Id. at 21.

C. The Court Should Defer to the Legislative Branch to Resolve the Policy Considerations.

The groups which comprise the Committee are no strangers to the policy considerations presented by this case. We have been arguing them in State legislatures across the country—an arena in which the insurance industry, organized labor and large employers are not exactly unrepresented. The prevalence of mandated benefit laws is eloquent testimony to the merit of the two opposing points of view.

Whatever one's views, however, it is clear that policy arguments should be made to the legislative branch. This is particularly true with respect to regulation of health care. Faced with serious problems of cost and availability, government on all levels has begun to develop policies appropriate to its sphere of activities. Significantly, many of the *amici* which urge federal preemption of this state initiative are active participants in the effort to expand state regulation of health care into other areas, particularly controls over the price of health care services.

The ultimate direction of this evolution in health care policy is uncertain. One thing is, however, certain: the choices will follow the kind of thorough debate of policy considerations that forms the basis of any reasoned legislative decision—in short, the kind of debate that did not occur in the Congress which enacted ERISA.

We urge this Court not to fill this vacuum with its own judgment. As the United States concluded its discussion of this issue:

> "Congress preserved authority in the states to regulate insurance, and if petitioners find the result

burdensome their recourse is to Congress, or to the state legislatures, rather than to this Court."

U.S. Memorandum, supra, at 9.

CONCLUSION

For the foregoing reasons, we urge the Court to affirm the judgment of the court below.

Respectfully submitted,

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APPENDIX

APPENDIX

DESCRIPTION OF PARTICIPANTS IN THE COMMITTEE FOR COMPREHENSIVE INSURANCE COVERAGE

State of Texas

The State of Texas has enacted mandated benefit laws for treatment of alcohol and drug abuse disorders.

State of North Dakota

In 1975, the State of North Dakota enacted mandated benefit laws for treatment of mental health, alcohol and drug abuse disorders.

National Mental Health Association

Founded in 1909, the NMHA is the nation's largest consumer advocacy organization for mental health dedicated to promoting mental health, preventing mental illness, and improving the care and treatment of mentally ill individuals. The 650 Mental Health Association local chapters and state divisions and its more than one million citizen volunteers work toward these goals through a wide range of activities in social action, education, advocacy and public information.

Alcohol and Drug Problems Association of North America, Inc.

Since its formation in 1949, the ADPA has sought unity of action for the benefit of individuals who suffer from alcohol and drug related problems. ADPA is a membership association consisting of alcohol and drug abuse professionals in all sectors of the field. Its services include advocacy and leadership on national legislative and public policy issues, sponsorship of a variety of conferences and professional education opportunities, and

publication of newsletters and information designed to disseminate current field developments to professionals.

National Association of State
Alcohol and Drug Abuse Directors

NASADAD is a not-for-profit organization composed of directors of State alcoholism agencies and of single State agencies for drug abuse prevention. The association was originally incorporated in 1971 to serve State drug agency directors; in 1978, the membership was expanded to include State alcoholism agency directors. NASADAD's basic purpose is to foster and support the development of effective alcohol and drug abuse prevention and treatment programs throughout every State.

National Council on Alcoholism, Inc.

The NCA is the only national voluntary health organization founded to combat alcoholism. Since 1944, it has fought to reduce the stigma attached to this tragic disease and to gain recognition for it as a major national health problem. NCA's main activity is educating the public about alcoholism through its network of over 200 state and local affiliates. NCA offers vital information and referral services to alcoholics and their families, is their major advocate at the national policy-making level, and has been instrumental in the establishment of effective treatment services.

American Mental
Health Counselors Association

AMHCA is a multidisciplinary group of professional mental health counselors, working in a wide range of settings, dedicated to maintaining and improving the quality of mental health services and its providers by promoting licensure and certification, improved training standards, freedom of choice and client advocacy. AMHCA has sponsored the creation of the National Academy of Certified Clinical Mental Health Counselors, the recognized certification body for mental health counselors. With nearly 9,000 members, the American Mental Health Counselors Association is the second largest division of the American Association for Counseling and Development.

Association of
Mental Health Administrators

AMHA is composed of administrators of institutions, community mental health centers and programs dealing with mental illness, mental retardation, developmental disabilities, alcoholism and drug abuse.

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Association of Psychiatric
Outpatient Centers of America

Membership consists of individual outpatient psychiatric centers. There are 109 members in the United States and Canada.

International Association of
Psycho-Social Rehabilitation Services

IAPSRS is a non-profit, membership association of organizations and individuals involved in providing community-oriented services to psychiatrically disabled adults. Primarily based in the United States, the Association's purpose is to advance the role, scope and quality of services designed to facilitate the community readjustment of the psychiatrically disabled.

National Alliance for the Mentally Ill

NAMI is a self-help movement of families, friends, and former mental patients that advocates for the chronically mentally ill, including research into the causes and treatment of mental illness and support services for mentally ill persons, and that provides information, education, and emotional support to families with a member afflicted

with serious mental illness. Since its inception in 1979, NAMI has rapidly developed into a national movement with 363 affiliates including 20 statewide associations in all 50 states with nearly 30,000 family members that are united in their common cause through the national office in Washington, D.C.

National Association of State Mental Health Program Directors

NASMHPD is the mental health arm of the National Governors' Association. The NASMHPD membership consists of the agencies in each of the 55 states and territories that administer and fund the state government programs serving mentally disabled persons. The NASMHPD member agencies expend $8 billion annually in the care of mentally ill people. Many of the member agencies also administer programs for the mentally retarded, developmentally disabled, alcohol abusers and drug abusers, totally an additional $5 billion.

National Council of Community Mental Health Centers

Founded in 1970, the National Council represents more than 700 agencies comprising some 62,000 staff and board members nationwide. Through its sections and divisions, the National Council also provides membership opportunities for individuals who share common interests in specialized areas of community mental health.

American Association for Marriage & Family Therapy

The Association represents over 11,000 family therapists. It sets high standards for clinical practice, promotes professional education, accredits educational and training programs, publishes professional journals, and is active in public policymaking.

American Dental Association

The ADA is a voluntary, nonprofit organization of 130,000 dentists dedicated to encourage the improvement of the health of the public and to promote the art and science of dentistry.

American Nurses' Association, Inc.

ANA is a not-for-profit professional organization representing approximately 180,000 registered nurses who are members of ANA's constituent associations in the 50 states, the District of Columbia, the Virgin Islands and Guam. Approximately 12,000 registered nurses are members of ANA's constitutent in the Commonwealth of Massachusetts. The Council on Psychiatric and Mental Health Nursing exists within the structure of ANA to foster high standards of psychiatric/mental health nursing practice and to facilitate the advancement of psychiatric/mental health nursing as a significant specialty in the mental health field.

American Occupational Therapy Association, Inc.

AOTA is a nonprofit association of health professionals that was founded in 1917 and now represents over 39,000 registered occupational therapists, certified occupational therapy assistants, and students of occupational therapy. Affiliated with the national Association are associations located in each state, the District of Columbia, and Puerto Rico. The health professionals represented by the AOTA specialize in increasing the independent functioning and productivity of people of all ages who are physically, psychologically, or developmentally disabled.

American Podiatry Association

APA is a professional society with 8,500 members in 52 component societies, one in each state, Puerto Rico, and the District of Columbia. It has two main objectives:

(1) to create greater public awareness of the benefits of good foot care; and (2) to encourage and initiate programs to meet the foot health needs of an expanding population.

Child Welfare League of America, Inc.

The League is a privately supported organization of over 300 child welfare agencies and 1200 affiliates whose efforts are directed to the improvement of care and services to children and their families. The League was the first national, not-for-profit voluntary membership organization which set standards for child welfare services in the United States and Canada. League member agencies provide a variety of services, including day care, residential and group care, foster family care, day treatment, protective services, maternity care, and shelter care.

Family Service America

FSA represents 280 family service agencies in the United States and Canada. Founded in 1911, it is the leading organization in the family service movement in North America. Through its member agencies, approximately 3 million persons annually receive direct services and programs to resolve issues of family life.

National Association of Reimbursement Officers

NARO is a professional organization of employees from small, medium, and large governmental agencies who are directly involved in multi-faceted private and public reimbursement programs. NARO members are public or nonprofit employees representing a cross section of many disciplines from states, counties, and communities. Core membership is directly engaged in or is responsible for reimbursement of costs related to governmental health care agencies. Other members are from medical and related services, legal services, and administrative services. This year NARO celebrates its thirtieth (30th) anniversary.

National Association of Social Workers, Inc.

NASW is a non-profit national organization of professional social workers which is devoted to the advancement of sound public policy for the consumers of social work services as well as for social work professionals. More than one-third of its 98,000 members are engaged in providing health and mental health services in public, voluntary and private institutional and outpatient settings throughout the country.

National Federation of Societies For Clinical Social Work, Inc.

NFSCSW is a federation of state organizations working to advance the interests of clinical social workers and their patients in state and federal mental health programs; increase the knowledge and skills of individual social workers through sponsorship of continuing education programs and professional publications; expand the availability and accessibility of mental health services by promoting the inclusion of clinical social workers as reimbursable providers of mental health services in group health insurance programs; and assure consistently high quality and integrity of services rendered to patients by promoting high standards for licensure and certification of clinical social workers.